Catholic Healthcare West d/b/a Mercy Sacramento Hospital d/b/a Mercy General Hospital d/b/a Methodist Hospital d/b/a Mercy Hospital Folsom d/b/a Mercy Medical Center San Juan *and* International Union of Operating Engineers, Stationary Engineers Local 39, AFL–CIO, Petitioner. Case 20–RC–17967

June 1, 2005

DECISION ON REVIEW AND ORDER

BY CHAIRMAN BATTISTA AND MEMBERS LIEBMAN AND SCHAUMBER

The issue in this case is whether the petitioned-for skilled maintenance employees in a presumptively appropriate single-facility unit is appropriate for bargaining. On July 16, 2004, the Regional Director for Region 20 issued a Decision and Direction of Election (pertinent portions are attached as an appendix) in which he found that the Employer met its burden to rebut the single-facility presumption, and that the petitioned-for unit must include the skilled maintenance employees at all four acute care hospitals within the Mercy Healthcare Sacramento (MHS) subdivision of Catholic Healthcare West (CHW).

Thereafter, in accordance with Section 102.67 of the Board's Rules and Regulations, the Petitioner filed a timely request for review of the Regional Director's decision. On September 15, 2004, the Board granted the Petitioner's Request for Review.

Having carefully reviewed the entire record,[1] we reverse the Regional Director, and find that the Employer has failed to sustain its burden of establishing that the petitioned-for single-facility unit of skilled maintenance employees is not appropriate for bargaining.

It is well established that a single-facility unit in the health care industry is presumptively appropriate. *Manor Healthcare Corp.*, 285 NLRB 224 (1987). See also, *St. Luke's Health System, Inc.*, 340 NLRB No. 139, slip op. at 2 (2003); *Visiting Nurses Assn. of Central Illinois*, 324 NLRB 55 (1997); *Children's Hospital of San Francisco*, 312 NLRB 920, 928 (1993), enfd. *California Pacific Medical Center v. NLRB*, 87 F.3d 304 (9th Cir. 1996); *Mercy Health Services North*, 311 NLRB 367 fn. 2 (1993). As the party opposing the single-facility unit, the Employer has the heavy burden of overcoming the presumption. *Trane*, 339 NLRB 866 (2003); *Visiting Nurses Association of Central Illinois*, supra. In order to rebut the presumption, the Employer must demonstrate integration so substantial as to negate the separate identity of the single facility. *Heritage Park Health Care Center*, 324 NLRB 447, 451 (1997)**,** enfd. 159 F.3d 1346 (2d Cir. 1998)**.** The Board examines factors such as centralized control over daily operations and labor relations, including the extent of local autonomy; the degree of employee interchange, transfer, and contact; functional integration; similarity of skills, functions, and working conditions; geographic proximity; and bargaining history. *New Britain Transportation*, 330 NLRB 397 (1999); *West Jersey Health System*, 293 NLRB 749, 751 (1989). Moreover, the Board considers the degree of interchange and separate supervision to be of particular importance in determining whether the single-facility presumption has been rebutted. *Passavant Retirement & Health Center*, 313 NLRB 1216, 1218 (1994); *Heritage Park Health Care Center*, supra. In the health care industry, the Board also examines whether a single-facility unit creates an increased risk of work disruption or other adverse impact upon patient care should a labor dispute arise. *Manor Healthcare*, supra at 226. The Board has frequently found single-facility units in hospitals and other health care settings to be appropriate. See, e.g., *Heritage Park Health Care Center*, supra; *Children's Hospital of San Francisco*, supra; *Staten Island University Hospital*, 308 NLRB 58, enfd. 24 F.3d 450 (2d Cir. 1994); *O'Brien Memorial*, 308 NLRB 553 (1992); *Pomona Golden Age Convalescent Home*, 265 NLRB 1313 (1982); *Samaritan Health Services*, 238 NLRB 629, 632–633 (1978); *National G. South, Inc.*, 230 NLRB 976 (1977); *Saint Anthony Center*, 220 NLRB 1009 (1975); *Jackson Manor Nursing Homes*, 194 NLRB 892, 894–896 (1972).

In this case, the record establishes that the petitioned-for Mercy General Hospital is a large, acute care facility with 400 beds and 800 employees. The Employer's central office negotiates union contracts, advises on grievance matters, and directly handles grievances at the third step and beyond. The central office also participates in a panel that hears employee appeals from adverse actions. In addition, the nonrepresented employees at all four facilities share uniform pay rates and benefits. The Employer has a uniform set of personnel policies and procedures for all of its MHS facilities. Moreover, the Employer operates on a centralized basis between its four facilities with respect to payroll processing, accounting, purchasing, information systems, risk management, and safety and security functions.

[1] The Employer only presented one witness, and the entire record consists of 61 pages.

Mercy General operates with substantial local autonomy, notwithstanding the high degree of centralization of administration and labor policies among the four MHS facilities. It has its own management structure, with many layers of supervision, including its own president. It has its own human resources department whose director reports to the hospital's president. Further, there is an immediate supervisor who supervises the petitioned-for skilled maintenance employees. This supervisor reports to another local manager within the hospital, who in turn reports to the hospital's director of ancillary services. The director of ancillary services reports to the hospital's president.

The immediate supervisor of the petitioned-for skilled maintenance employees has the authority to assign work to these employees. He may also discipline them and prepare their performance appraisals (or the appraisal may be handled by his superior at Mercy General), as long as his actions conform with the CHW/MHS policies and procedures.[2] The management of each individual hospital in MHS handles its own scheduling, and there are differences among facilities as to evening and night shift coverage requirements for the skilled maintenance employees.

Further, local management handles the first two steps of the grievance procedure. Although the CHW director of labor and employee relations, who represents the MHS hospitals in labor relations matters, plays a consultative role to local management in the first two steps of the grievances involving unionized employees, there is no indication that he plays this role in the first two steps of the dispute resolution procedure for nonunionized employees.

In addition, the local managers at Mercy General Hospital make decisions about local hiring. After new job applicants are screened on a centralized basis, the local managers interview the applicants at their own facility. Local managers then make the decision about whether to hire an applicant, subject to reversal at the MHS divisional level only if there are conflicts with CHW/MHS policies or problems with background checks and drug testing.

Thus, while there are common labor relations policies among the facilities, and some centralized administration of certain labor relations matters, such as grievance handling and hiring, the day-to-day labor matters are administered locally within each facility. The dissent argues that the centralization of administrative functions and certain labor relations matters support a multifacility unit. We find, however, that the centralization of these functions is not sufficient to negate the separate identity of Mercy General, particularly in light of the substantial local autonomy and lack of employee contact and interchange. See *Heritage Park Health Care Center*, supra; *Children's Hospital of San Francisco*, supra; *Staten Island University Hospital*, supra; *O'Brien Memorial*, supra; *Pomona Golden Age Convalescent Home*, supra; *Samaritan Health Services*, supra; *National G. South, Inc.*, supra; *Saint Anthony Center*, supra; *Jackson Manor Nursing Homes*, supra.

Further, the departments at each of the hospitals within the MHS system formulate their own departmental budgets, which are approved at the individual hospital level and then submitted to CHW's chief operating officer for approval as part of the overall MHS budget. Personnel files and patient files are maintained at each individual hospital.

The Employer also failed to establish that there is substantial contact and interchange between the petitioned-for employees and the skilled maintenance employees at other facilities. The record shows that employees are routinely assigned to work at a single MHS facility, and that temporary transfers are the exception rather than the norm. Although the skilled maintenance employees perform single and multiday projects at other facilities, usually in order to make adjustments to machinery, there is no evidence about how often this occurs.

The Employer has similarly not provided evidence of substantial permanent interchange. The Regional Director emphasizes that the Employer's system of posting open positions at all facilities and using common seniority in bidding for jobs is by nature conducive to permanent transfers systemwide. However, if there is a job opening at a facility and there other employees performing the same type of work at that facility on different shifts, those employees are given the first priority in bidding on the open shift at their site. Moreover, there is no specific evidence to establish how often permanent transfers occur either throughout the system or with respect to the petitioned-for facility. In any event, it is well established that the Board considers permanent transfers to be a less significant indication of actual interchange than temporary transfers. *Red Lobster*, 300 NLRB 908, 911 (1990).

The geographic distance between the petitioned-for facility and the other three facilities in the MHS system further supports the appropriateness of a separate unit. These hospitals are 12 to 20 miles away from Mercy General. Under similar circumstances, the Board has found single-facility units to be appropriate. See *New*

[2] The supervisor or his superiors consult with the human resources director at Mercy General on these matters, and this local human resource director would only consult the CHW director of labor and employee relations on nonroutine matters.

Britain Transportation Co., supra; *O'Brien Memorial, supra; Manor Healthcare Corp*., supra at 227.

Further, we disagree with the Regional Director's finding that the history of collective bargaining in the MHS-wide units represented by the California Nurses Association and SEIU Local 250 is more relevant to this case than the certification issued in 1998 in the single-location skilled maintenance unit at Methodist Hospital in Case 20–RC–17442.[3] Those multifacility units did not involve the classification of employees sought here. Moreover, the parties agreed on the unit scope in those situations, unlike in the Methodist Hospital case. Although the Regional Director found that there was no history of collective bargaining in the single-facility unit prior to the Union's disclaiming interest in August 2000, this is inconsistent with his earlier finding that bargaining did occur, albeit no collective-bargaining agreement was reached. Indeed, the record shows that the parties bargained for an extended period of time. Contrary to the dissent's suggestion, the parties' failure to reach a contract does not negate the single-facility bargaining history or its relevance. Thus, although we agree with the Regional Director that this single-facility bargaining history is not controlling, we do not agree that reliance should be placed on the multifacility bargaining history under the facts here.[4]

In sum, we find that the Employer has not met its burden to demonstrate that the integration among the MHS facilities is so substantial as to negate the separate identity of Mercy General. Mercy General has its own management structure and human resources department. Its local supervisors exercise substantial local autonomy with respect to such matters as assignment of work, discipline of employees, preparation of performance appraisals, scheduling, grievance handling, and hiring. In addition, Mercy General and other MHS hospitals formulate their own departmental budgets, subject to the approval of CHW's chief operating officer. Further, the record fails to establish substantial contact and interchange between the petitioned-for employees and the skilled maintenance employees at other facilities. The geographic distance between Mercy General and the other MHS facilities also supports the appropriateness of a separate unit. Finally, there is no determinative bargaining history.

The dissent's reliance on Congress' admonishment to the Board to guard against the undue proliferation of units in health care institutions is misplaced. In *Manor Healthcare*, the Board explained why applying the single facility presumption in the health care industry was not inconsistent with the Congressional admonition against undue proliferation of units. The basis for the admonition was Congress' concern that multiple bargaining units in healthcare could lead to increased strikes, jurisdictional disputes, and wage whipsawing that might disrupt the provision of health care. See *Manor Healthcare Corp.*, supra. However, the Board found that there was nothing in the legislative history to indicate that issues of unit scope, rather than unit composition, were a focus in this admonition. Id. at 226.[5] At the same time, in order to address the concerns about increased disruption in the health care industry, the Board found that the single-facility presumption could be rebutted by weighing, in addition to the usual community-of-interest factors, any evidence, presented in the employer's rebuttal case, demonstrating that approval of the single-facility unit will threaten the kinds of disruptions to continuity of patient care that Congress sought to prevent. Id. at 225, 226.

At the same time, the Board observed in *Manor Healthcare* that "[i]t is difficult to see how, as a practical matter, we would create a greater risk of the spread of work stoppages or other disruptions from one facility to another than we would by permitting representation only in a multi-facility unit." Id. at 226. To the contrary, the Board stated that "often the broader unit will increase the danger that a work stoppage will have an adverse impact on the delivery of health care services in a relevant geographical area–a result Congress could not have intended." Id.

Notably, courts have agreed with the Board's application of the single-facility presumption in the health care industry. See, e.g., *Massachusetts Society for the Prevention of Cruelty to Children v. NLRB*, 297 F.3d 41 (1st Cir. 2002); *NLRB v. Heartshare Human Services of New York, Inc.*, 108 F.3d 467, 471 (2d Cir. 1997); *Staten Island University Hospital v. NLRB*, 24 F.3d 450, 456–457

[3] A Decision and Direction of Election issued in this case on September 4, 1998. The Board denied review on October 14, 1998.

[4] Our dissenting colleague asserts that the Board's decision in *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975), enf. denied and case remanded 589 F.2d 968 (9th Cir. 1978), cert. denied 440 U.S. 910, 99 S.Ct. 1221, 59 L.Ed 2d 458 (1979), which found a multifacility unit appropriate, was consistent with the congressional mandate against proliferation. We find reliance on that case to be misplaced. There, the scope of the unit was agreed upon by the parties and was thus not at issue before the Board. Further, it appears that the single-facility presumption would in any event have been inapplicable, inasmuch as the petitioner sought a multi-facility unit. Finally, the Board made no mention of the congressional mandate as it related to the scope of the unit found appropriate.

[5] In enacting the Healthcare Rules, the Board indicated that "the proposed rule does not purport to address the issue of the appropriateness of the single facility when an employer owns a number of facilities, which the Board will continue to address through adjudication," citing *Manor Healthcare.* 284 NLRB 1532.

(2d Cir. 1994) (the Board has "good reasons to use the single-facility presumption"); *Local 144 v. NLRB*, 9 F.3d 218, 223–225 (2d Cir. 1993); *California Pacific Medical Center v. NLRB*, supra at 308–310 (single-facility presumption, rather than disparity of interests test, for unit scope determinations was appropriate for determining bargaining unit for nurses after merger of two hospitals 1 mile apart)

Here, the Employer has failed to show that allowing representation of employees at the Hospital alone in a single facility unit will have any greater impact on the provision of health care than that contemplated by the Board in *Manor Healthcare*, in Rulemaking, or in subsequent_cases. Indeed, the Employer does not assert, and there is no evidence to show, that a single-facility unit in this case would create an increased risk of work disruption or other adverse impact on patient care should a labor dispute arise. See, *Heritage Park Health*, supra, at 452; *Children's Hospital of San Francisco*, supra at 929; *Manor Healthcare Corp*., supra, at 228–229. Cf. *West Jersey Health System*, supra (a labor disruption at the petitioned-for single-facility units could adversely affect health care provision, where certain equipment was only available in some facilities and, in some instances, the employees who operated the equipment rotated from facility to facility, and all hot food served to patients and employees was prepared in one facility).

This case is distinguishable from *Stormont-Vail Healthcare, Inc.*, supra; *St. Luke's Health System*, supra; and *West Jersey Health System*, supra, relied on by the Regional Director. In *Stormont-Vail*, the Board found that the single-facility presumption did not apply because the parties in that case stipulated at the outset that a multifacility unit was appropriate. The Board found that the Regional Director arbitrarily excluded RNs in the employer's off-campus psychiatric facility, outlying clinics, and community nursing centers from the otherwise employerwide RN unit found appropriate. In this case, by contrast, the Petitioner seeks to represent only the skilled maintenance employees in the Mercy General facility, and the Employer seeks to add additional facilities. In addition, the unit at issue in *Stormont-Vail*, unlike here, did not comport with a coherent administrative, geographic, or supervisory grouping, and the amount of employee contact and interchange, and the integration of operations were greater in *Stormont-Vail* than here.

In *St. Luke's*, the Board found that the employer rebutted the single-facility presumption and thus the unit had to include all 21 clinics at 16 clinic locations. The evidence of regular interchange was more specific and substantial than here (up to 20% of the employees within all job classifications within the clinic work force floated to other locations in any given year), and there was very limited local autonomy accorded to the individual onsite clinic managers. In that case, unlike here, three directors oversaw the clinics' operations and were responsible for different functional areas. Local clinic managers exercised authority on pro forma matters such as developing inclement weather directives and smoking policies, scheduling employees, and making "time off" determinations. Although the local clinic manager decided which candidate to hire for his or her facility from the screened list (with background checks completed) provided by the human resources department, the human resources department possessed the authority to reverse a hiring decision or rescind a job offer. By contrast, in the instant case, the decisions of local managers are only reversed if the decision conflicts with CHW/MHS policies or there are problems with background checks or drug testing.

In *West Jersey Health System*, supra, the Board found that a system-wide multifacility unit was the only appropriate unit. In contrast to the present case, there were, among other things, significant permanent interchange and steady temporary interchange among the facilities. In addition, the Board found that a labor dispute would adversely affect the provision of health care.

Accordingly, based on the foregoing, we reverse the Regional Director's finding that the single-facility presumption has been rebutted. We remand the case to the Regional Director for further appropriate action.

ORDER

The Regional Director's Decision and Direction of Election is reversed, and the case is remanded to the Regional Director for further appropriate action.

Dated, Washington, D.C. June 1, 2005

Wilma B. Liebman, Member

Peter C. Schaumber, Member

(SEAL) NATIONAL LABOR RELATIONS BOARD

CHAIRMAN BATTISTA, dissenting.

My colleagues have found that a separate unit of skilled maintenance employees at the Mercy General Hospital is an appropriate unit. I disagree. I would affirm the Regional Director. I would find that the Employer was correct in asserting that the appropriate unit consists of the skilled maintenance employees at all of

the Employer's four facilities. All four facilities are in the Sacramento, California area.

I recognize that there is a presumption in favor of a single-facility unit. However, that presumption must be tempered by two important considerations: (1) Congress has admonished the Board to guard against the "undue proliferation of units in health care institutions";[1] (2) the history of collective bargaining of this Employer is consistent with that Congressional admonition.

In the latter regard, the Board has found multifacility units appropriate in *Mercy Hospital*, 217 NLRB 765, 766 (1975), and in *Mercy Hospital*, 244 NLRB 229 (1979). Similarly, in 20–RC–17195, the California Nurses Association was certified in a multifacility unit of the Employer. Finally, since 2000, SEIU Local 250 has represented a multifacility unit of employees of the Employer.[2]

As against this, there is only one situation where there was a single-facility unit. However, the Employer here was a mere holding company at the time of that case. The testimony in the instant case shows that the Employer is now the operational entity. Further, the bargaining in that unit came to naught. The Union was certified in 1998, no agreement was reached, and the Union disclaimed interest in 2000.

The specific facts of the instant case also support a multi-facility unit. The Regional Director, whose decision I would affirm, has comprehensively set forth these facts. I shall highlight only some of them.

The Employer centrally controls important labor relations matters. In regard to unionized facilities, the Employer's central office negotiates union contracts, advises on grievance matters, and directly handles grievances at the third step and beyond. In regard to nonunion facilities, the Employer's central office sets the pay, benefits, policies, and procedures. It also participates in the panel that hears employee appeals from adverse actions.

The Employer has a uniform set of personnel policies and procedures for all of its facilities. Evaluation criteria are the same at all hospitals. As noted above, pay and benefits for unionized facilities are negotiated by the central office. The pay and benefits for non-union employees are the same at all facilities. The skilled maintenance employees sought here do the same work as skilled maintenance employees at the other facilities, and their pay and benefits and other terms and conditions of employment are the same as at all other facilities.

If there is a vacancy at a facility, employees at all facilities can bid on it, and there is no preference given to applicants from the facility where the vacancy exists.[3] Seniority is employerwide and is used in selecting among bidders.

With respect to matters beyond labor and employment, the evidence shows that the Employer operates on a centralized basis as to such important areas as accounting, budgeting, purchasing, information systems, risk management, and safety and security functions.

I recognize that some day-to-day matters are decided locally. However, given the nature of these matters (work assignments, scheduling), it is not surprising that they are handled locally.

As to other day-to-day matters, they are subject to centralized control. For example, although the local supervisor can discipline employees and prepare evaluations, those actions must conform to central policies and procedures. Similarly, as to hiring, the process begins with centralized screening. A local decision to hire is subject to reversal, on stated grounds, by central authority. In short, centralized authority exercises control at the start and at the finish of the hiring process.

In sum, several of the day-to-day functions are subject to central control, and all of the major matters are subject to central control.

My colleagues rely on *Manor Healthcare*, 285 NLRB 224 (1987), for the proposition that the single facility presumption is not inconsistent with the Congressional admonition against undue proliferation of units in the healthcare industry. However, the Board there was careful to note that consideration of the Congressional policy is not foreclosed, i.e., an employer's rebuttal evidence is to be carefully considered in the context of that policy. As demonstrated above, I believe that the Employer's evidence here, particularly when weighed in the context of the Congressional policy, clearly demonstrates the inappropriateness of a single-facility unit. That is, the centralized control, the multifacility history, and the unsuccessful bargaining in a single-facility unit, all support the Employer's rebuttal.

[1] S. Rept 93-766, 93d Cong., 2d sess. 5 (1974); see also H Rept. 93-1051, 93d Cong., 2d sess. (1974). 120 Cong. Rec. S. 6940 (1974). 120 Cong. Rec. S. 7311 (1974).

[2] In citing the Board cases supra, I am not suggesting that the Board has definitively ruled on the issue of single vs. multifacility units as to the Employer. I cite the cases because they are relevant to the factor of bargaining history.

My colleagues say that these cases involve nurses rather than maintenance employees involved herein. However, the concern about undue proliferation is obviously not confined to the type of separate unit that is sought.

[3] There is one exception, i.e., a preference is given to an employee who performs the same work at that facility (on a different shift).

Based on all of the above, I would not "proliferate" the units by separating out this single facility.[4] That would be contrary to the Congressional admonition, the bargaining history of this Employer, and the facts of this case.

Dated, Washington, D.C. June 1, 2005

Robert J. Battista , Chairman

NATIONAL LABOR RELATIONS BOARD

APPENDIX

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By its amended petition, the Petitioner seeks to represent a unit comprised of all full-time and regular part-time engineers, carpenters, maintenance technicians and bio-medical technicians employed at the Employer's Mercy General Hospital facility located in Sacramento, California; excluding all other employees, groundskeepers, guards and supervisors as defined in the Act. There are approximately 17 employees in the petitioned-for unit. The Employer contends that in order to be appropriate, the unit must include employees in the petitioned-for classifications at all of the hospitals within the CHW subdivision called Mercy Healthcare Sacramento (MHS), which, as discussed below, is comprised of four acute care hospitals located in the Sacramento area. There are about 60 employees in the unit that the Employer contends is the appropriate unit.

The only witness to testify at the hearing was CHW's Director of Labor and Employee Relations, Renae Bugge.

The Employer's Operation. The petitioned-for employees work at Mercy General, a 400-bed hospital employing about 800 employees that is within the MHS subdivision of CHW. CHW is a multi-hospital healthcare system doing business in California, Arizona and Nevada. It includes primary acute care hospital facilities as well as some non-acute care medical facilities. Since the late 1980s or early 1990s, MHS has been a subdivision of CHW, that includes four acute care hospitals, Mercy General Hospital, Methodist Hospital, Mercy Hospital Folsom, and Mercy Medical Center San Juan. Until the late 1990s, the CHW/ MHS system also included another acute care facility, Mercy American River Hospital, which is no longer part of the system.

All four MHS hospitals are located in the Sacramento area. Specifically, Mercy General and Methodist Hospital are both located in the City of Sacramento. Methodist Hospital is located in the southern part of the City, just north of the town of Elk Grove. Mercy General is situated near downtown Sacramento, about 12 to 15 miles north of Methodist Hospital. Northeast of Sacramento, in the City of Citrus Heights, is Mercy Medical Center San Juan (herein called Mercy San Juan), which is about 15 miles from Mercy General. Mercy Hospital Folsom (herein called Mercy Folsom) is located in the City of Folsom, which is located about 20 miles from Mercy General and about 15 miles from Mercy San Juan. MHS also has a business administrative office located in Rancho Cordova, California, which provides most of the centralized services for all four MHS hospitals, including patient accounting, payroll, human resources, payor contracting, marketing, information systems, risk management, safety and security and the Employer's legal department. The Rancho Cordova office is also in the Sacramento area and is located about the same distance from all four MHS facilities.

Mercy General and Mercy San Juan are much larger hospitals than Mercy Hospital Folsom and Methodist Hospital. At the time of the Decision and Direction of Election in Case 20-RC-17442, in 1998, which is discussed below, Mercy General included the main hospital and a medical office condominium building. The record does not disclose any changes in the Mercy General campus since that decision issued.

Collective Bargaining History. I take administrative notice that on September 4, 1998, the Acting Regional Director of Region 20 issued a Decision and Direction of Election in *Mercy Healthcare Sacramento d/b/a Methodist Hospital*, Case 20–RC–17442, finding that a petitioned-for unit of "all full-time and regular part-time maintenance technicians, engineers, biomedical equipment technicians and bio-medical maintenance technicians employed by the Employer at its Methodist Hospital facility located in Sacramento, California; excluding all clerical employees, guards and supervisors as defined in the Act," constituted an appropriate unit. This finding was based on the conclusion that the Employer in that case had failed to rebut the presumption that the petitioned-for single location unit was an appropriate unit. As in the instant case, the Employer therein contended that the only appropriate unit was one comprised of employees in the petitioned-for classifications working at all of the MHS hospitals, which at that time included the four hospitals involved in the instant case as well as Mercy American River Hospital, which the Employer no longer operates. The record shows that the Petitioner and the Employer bargained in the unit certified in Case 20–RC–17442, but no collective bargaining agreement was ever reached. Employer Director Bugge incorrectly testified at the hearing that the unit at Methodist Hospital had been decertified. I take administrative notice that in Case 20–RD–2299, by letter dated August 7, 2000, the Petitioner disclaimed interest in representing the unit certified in Case 20–RC–17442 and the decertification petition in that case was withdrawn on August 8, 2000.

The California Nurses Association (herein referred to as the CNA) was certified on December 23, 1996, in Case 20–RC–17195, to represent employees in a multi-location unit that includes the four MHS hospitals herein as well as additional CHW medical facilities in the Sacramento area. Administrative notice is taken of the fact that this unit was certified pursuant to the results of a stipulated election proceeding. Since 1996, the CNA has represented registered nurses in the MHS unit. Overall, it represents registered nurses at twenty CHW facilities.

Since approximately 2000, SEIU Local 250 has represented non-professional and technical employee units covering employees at all four MHS hospitals and at a non-acute care medi-

[4] It would seem obvious that the prospects for periodic strikes and whipsaw tactics are greater where there are four separate units rather than one unit.

cal facility within MHS. These units were not certified by the Board. In its brief in this case, the Employer's counsel represented that SEIU Local 250 has consolidated all of its CHW bargaining units, including the MHS hospital unit, for purposes of negotiating with CHW. She further asserts that SEIU Local 250 continues to have a single local supplement to its agreement for MHS. Director Bugge testified that certain contractual provisions of the SEIU Local 250 contract apply uniformly to all CHW employees represented by the SEIU Local 250, and certain provisions apply only to those within the MHS system.

I also take administrative notice of two earlier Board decisions involving the same facilities, *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975), and *Mercy Hospitals of Sacramento*, 244 NLRB 229 (1979), where multi-location units of professional employees, service and maintenance and office clerical employees at Mercy General and Mercy San Juan were found to be appropriate units.

Administrative and Labor Relations Functions and Policies. CHW Director Bugge testified that in 1998, when the Decision and Direction of Election in *Mercy Healthcare Sacramento d/b/a Methodist Hospital*, Case 20–RC–17442, issued, CHW served only as a holding company, which loosely bound together the many hospitals within CHW. In 1998, approximately four regions existed within CHW with MHS operating as an entity within this regional structure. These regions were subsequently changed into two divisions with MHS operating as part or all of one of these divisions of CHW. According to Bugge, since 1998, CHW has developed into an operating entity rather than a holding company, and its board of directors has assumed a much greater degree of control over its constituent hospitals. Many of the operating hospital and community boards within the system have been dissolved or restructured such that CHW now operates as a single employer.

CHW Director Bugge represents the MHS hospitals in labor relations matters, and is involved in negotiating union contracts, advising hospital management on grievance administration and handling, and assisting individual hospitals in dealing with union organizing and election matters. In addition to Bugge, there is also common human resources leadership over MHS by CHW Vice President of Human Resources Tracy Church. With regard to grievance administration under union contracts, Bugge is involved in a consultative capacity in the early steps of the grievance procedure at all four MHS hospitals and is involved directly at the third step of the grievance procedure. The Employer also has a uniform multi-step dispute resolution procedure for non-represented employees at all four MHS hospitals, with the first two steps of this procedure taking place at the local hospital level with hospital supervisors and/or managers. If a grievance is not resolved at the local level, the employee can appeal to an MHS panel where the employee and the Employer each choose panel members and the decision of the panel is final and/or the dispute may proceed to arbitration. CHW Director Bugge is the Employer's representative on that panel. In this regard, she testified that she had not been involved in any dispute resolution proceedings involving any employees in the petitioned-for unit within the past year.

The Employer has a uniform set of personnel policies and procedures for employees at all MHS hospitals. Revisions to these personnel policies are the responsibility of the Employer's human resources council, which is comprised of human resources administrators, benefits and compensation managers and training managers from each MHS facility, as well as CHW Director Bugge. The council meets on a monthly basis.

The Employer also has a labor strategy group comprised of CHW Director Bugge, CHW's Chief Operating Officer Bill Hunt, the MHS director of finance, and the president, nurse executive and ancillary service director of each of the four MHS hospitals. This group provides bargaining strategies on local practices for all MHS hospitals, such as the posting of jobs and floating between facilities. On global issues, the group serves in an advisory capacity to CHW bargaining strategy leaders such as Bugge. This group meets three or four times a year and more often as needed during contract negotiations. According to Bugge, there are no committees at the individual MHS hospitals that set labor policy.

Transfers & Hiring Procedures. The record reflects that where an opening exists at a facility and there are other employees performing the same type of work at the same facility on different shifts, they are given the first priority in bidding on the open shift at their site. Otherwise, job openings for all MHS hospitals are combined on a single integrated list and distributed to each MHS facility and seniority for purposes of applying for open positions is determined on an MHS-wide basis among employees at all MHS hospitals. Employees of MHS hospitals are also given priority to transfer into open positions before persons are hired from outside MHS.

New job applicants are screened on a centralized basis and then their applications are distributed to individual hospitals based on where an open position exists and where the applicant prefers to work. The applicant is then interviewed at the individual facility by the supervisor and/or manager at that facility, who makes the decision of whether to hire the applicant. This decision is then communicated back to the centralized recruiter or employment specialist for all four MHS facilities, who determines whether the selection comports with CHW/MHS policies and the results of background checks and drug testing results received after the applicant was referred to the facility for interviewing. If there are no problems with the hiring decision, the recruiter sends out a letter informing the applicant that he or she has been hired. If the recruiter or employment specialist does see a problem, then the hospital supervisors or managers who made the hiring decision are asked to consider other job applicants.

All four MHS hospitals utilize the same common format for job descriptions and evaluation forms and employees are evaluated under the same standardized criteria. However, Director Bugge testified that job descriptions are individualized for each employee with different performance standards and specific tasks outlined in the description. Bugge further testified that she is not involved in the appraisal process for the employees in the petitioned-for unit and that appraisals are handled either by the immediate supervisor of these employees at Mercy General or his superior at that facility.

The Employer has a uniform probationary period of ninety days and a uniform reduction in force procedure for all MHS hospitals. All MHS hospitals use similar employee identifica-

tion badges with the MHS logo, except that the badges identify the individual hospital where the employee works.

Nonrepresented employees at all four MHS hospitals have uniform pay rates and benefits. There is a centralized payroll and benefits administration system for all four MHS hospitals located at the Rancho Cordova office. There is also a common patient accounting system. The MHS facilities have a common marketing strategy department and a common information technology system that is contracted out to the same entity, Perot Industries. The MHS hospitals also use the same fundraising foundation.

MHS has a consolidated budget process. Departments at each hospital within the MHS system formulate their own departmental budgets, which are approved at the individual hospital level and then submitted to CHW's chief operating officer for approval as part of the overall MHS budget. Purchasing for all four MHS facilities is done by a single centralized purchasing entity.

Personnel files and patient files are maintained at each individual hospital. Bargaining, financial, payroll and patient registration records are maintained for all MHS hospitals at the Rancho Cordova office.

Supervision Of the Petitioned-For Employees. The petitioned-for employees report to Mercy General Supervisor Jim Peterson. Peterson reports to another manager within Mercy General, who in turn reports to the Hospital's director of ancillary services, who in turn reports to the Hospital's president. Each of the four hospitals within MHS is headed by a separate president and each hospital also has its own human resources department and its own human resources director, who reports to the hospital's president. The president of each hospital reports to CHW's Chief Operating Officer Bill Hunt. Hunt's jurisdiction covers not only the MHS hospitals but also CHW facilities throughout Northern California.

As indicated above, interviewing for jobs is conducted at the individual hospitals and hiring decisions are made by supervisors and/or managers at each hospital but are subject to reversal at the MHS divisional level if there are conflicts with CHW/MHS policies or problems with background checks or drug testing.

Supervisor Peterson has the authority to assign work to employees within the petitioned-for unit and he can also discipline them and prepare their performance appraisals, so long as his actions conform with CHW/MHS policies and procedures and he or his superiors at Mercy General consult with the human resources director of Mercy General, Linda Gregory, who reports to Mercy General's president. According to Director Bugge, Gregory is authorized to advise Peterson on all "routine" matters, but if an issue is "out of the ordinary," the hospital consults with CHW Director Bugge.

The management of each individual hospital in MHS handles its own scheduling and there are differences between facilities as to p.m. and night shift coverage requirements.

Employee Functions and Skills. No job descriptions for the petitioned-for employees are in evidence. Bugge testified that although job descriptions for employees are individualized and she was not familiar with the specific job descriptions for employees in the petitioned-for unit, many of the jobs they perform would be standard with some variations due to the nature of the equipment in use at different facilities.

Interchange. The record shows that the Employer has an MHS-wide system of job postings and utilizes MSH-wide seniority in bidding for jobs. Although Director Bugge testified that employees are routinely assigned only to work at a single MHS facility, and that temporary transfers are the exception rather than the norm, she further testified that skilled technicians do perform single and multi-day projects at other facilities, usually in order to make adjustments on machinery.

Analysis. No party disputes that the petitioned-for unit is comprised of skilled maintenance employees, one of the eight units deemed appropriate by the Board in its Health Care Rule. 54 Fed. Reg. 16336, 16347–16348, 284 NLRB 1579, 1596–1597 (1989). Nor do the parties dispute the individual unit inclusions or exclusions. The only issue is whether the petitioned-for unit, which is limited to skilled maintenance employees at Mercy General, is an appropriate unit, or whether the unit must also include skilled maintenance employees at all MHS hospitals. The Employer contends that the unit must include employees in the petitioned-for classifications at all MHS facilities, and the Petitioner takes the position that the petitioned-for single location unit at Mercy General is presumptively an appropriate unit.

The Board applies a presumption that a single-facility unit in the health care industry is appropriate. *Manor Healthcare Corp.*, 285 NLRB 224 (1987); *Heritage Park Health Care Center*, 314 NLRB 1318 (1997); *Lutheran Welfare Services of Northeastern Pennsylvania*, 319 NLRB 886 (1995). This presumption can be overcome by showing that the single facility is so effectively merged into a more comprehensive unit, or so functionally integrated, that it has lost its separate identity. *D&L Transportation*, 324 NLRB 160 (1997). In determining whether the single-facility presumption has been rebutted, the Board examines the following factors:

1) Geographic proximity of the employees in question;
2) Similarity of employee function and skill;
3) Similarity of employment conditions;
4) Centralization of administration;
5) Managerial and supervisory control of employees;
6) Employee interchange;
7) Functional integration of the employer;
8) Bargaining history.

See *In re Stormont-Vail Healthcare, Inc*., 340 NLRB No. 143 (2003); *St. Luke's Health System, Inc.*, 340 NLRB No. 139 (November 28, 2003); *University Medical Center*, 335 NLRB 1318 (2001); *Hartford Hospital*, 318 NLRB 183, 191 (1995); *Staten Island University Hospital v NLRB*, 24 F.3d 450 (2d Cir. 1994); *Passavant Retirement & Health Center*, 313 NLRB 1216, 1218 (1994); *Toledo Hospital*, 312 NLRB 652, 652, (1993); *West Jersey Health System*, 293 NLRB 749, 751 (1989).

As in *St. Luke's Health System*, *In re Stormont-Vail*, and *West Jersey Health System*, the Employer herein has a high degree of functional integration. Thus, the record establishes a high degree of administrative centralization between its four MHS facilities that includes centralized payroll processing,

accounting, purchasing, information systems, risk management and safety and security functions. This uniformity also extends to labor relations policies, including a common employee manual, the same pay rates and benefits, and the same hiring and dispute resolution policies.

CHW/MHS management has veto power over the decision-making of local hospital management in personnel matters such as hiring and firing and handles the dispute resolution procedure after step 2, as was the case in *West Jersey Health System*, 293 NLRB at 750. In addition, policy making in labor relations is handled jointly by officials of all four MHS hospitals together with CHW/MHS officials. The record also shows that most of the work of the employees in the petitioned-for classifications is similar at all facilities.

With regard to interchange, the record shows that the Employer has a system of posting open positions at all facilities and common seniority is used in bidding on jobs. Such a system is by its nature conducive to permanent transfers facility-wide. In addition, Bugge testified that skilled maintenance employees sometimes work on single or multiday projects at other than their assigned facility in order to make adjustments on equipment.

The geographic separation between these facilities is of no greater magnitude than that present in *Stormont-Vail Healthcare*, *St Luke's Health System*, and *West Jersey Health System*, all cases in which the Board found that the single location presumption had been rebutted.

Finally, with regard to the factor of collective-bargaining history, it has been over five years since the certification issued in the single location unit at Methodist Hospital in Case 20–RC–17442. The record reflects that the Employer has become more centralized in its operations and administrative functions as well as its handling of labor relations matters during those intervening years. Furthermore, there is no history of collective bargaining in the unit certified in that case. No contract was ever reached between the Employer and the Petitioner covering that unit, and in 2000, the Petitioner disclaimed interest in representing that unit. By contrast, there has been successful bargaining in the MHS-wide units represented by the CNA and SEIU Local 250. For these reasons, I find that the certification in the prior case is not controlling to my determination herein. Rather, I find that the history of collective bargaining in the other MHS-wide units, which is ongoing, is the more relevant consideration with regard to the appropriate unit in this case.

In sum, based on a careful consideration of the foregoing factors, I have concluded that the single facility presumption of appropriateness has been rebutted in this case and that the four-hospital MHS unit is the appropriate unit for collective-bargaining purposes. I note that this finding comports with the Board's policy against proliferation of units in the health care industry.

Accordingly, I am directing an election in the MHS-wide unit.